

VOLUME 3

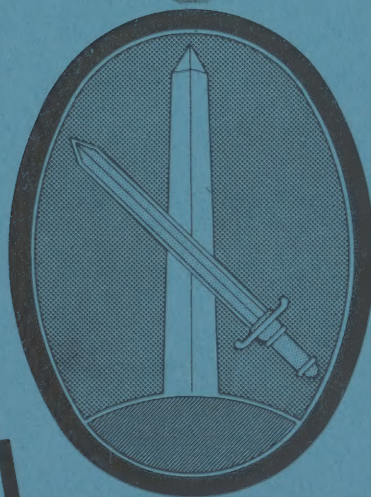
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REPORT NO. 3

RESTRICTED

# MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

March 1950





# MONTHLY REPORT

## M D W

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## HEALTH



HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
Washington 25, D. C.

**RESTRICTED**

MARCH 1950  
Vol. 3, No. 3







## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

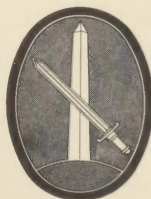
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as the basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department personnel in the field.

ROBERT E. BITNER  
Colonel, MC  
Surgeon

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## PROFESSIONAL SERVICES

### OCCULAR ELEMENTS IN DERMOID CYST OF OVARY

Lt. Col. George A. Heffernon, Station Hospital, Ft Belvoir, Va.

In 1947 there was reported in the American Journal of Obstetrics a case of bilateral dermoids of the ovaries associated with a ten weeks pregnancy. This apparently was the first case reported wherein a pregnancy had occurred in spite of dermoids of both ovaries. Recently in the Army Medical Bulletin there was reported by this writer a case of bilateral dermoids of the ovaries associated with a normal full term pregnancy. Now we have an opportunity of reporting a case of equal interest because of the contents of the cystic ovary.

It is the usual thing to find combinations of entoderm, ectoderm, and mesoderm anlage in dermoid cysts such as skin, hair, teeth, etc.---these structures being elements of the included twin from whom the dermoid is taken. It is not usual, however, to find combinations of such structures as to produce complete and near complete organs such as an eye and ear, a heart, etc. The following excerpt of the pathology report in the case of I.H. describes in the dermoid cyst of the ovary the presence of an eye with upper and lower lids.

This patient, when first seen, complained of excessive intermenstrual bleeding. On examination a mass about the size of a lemon could be felt in both adnexal regions associated with an enlarged non pregnant uterus. At operation a left polycystic ovary was removed as it contained no normal tissue. The right ovary felt as if it were filled with dry corn flakes. It too was removed in toto. As there was no ovarian tissue remaining a supravaginal hysterectomy was also performed. The pathological findings so far as they pertained to the ovary were as follows:

"The specimen is a large cystic structure measuring 12 x 10 x 9 cm. which is smoothly encapsulated, quite firm and is seen to be filled with long black hair and sebaceous material. On opening the cyst a very abundant amount of hair and greasy lardaceous or sebaceous material is evacuated. The cyst's inner diameter measures 9 cm. Along one wall there is a fleshy protuberant which measures 4.5 cm. in height, is 2.5 cm. in diameter. It has the characteristics of skin and from it numerous hairs protrude. The large cyst is thin-walled and the mound structure when sectioned is found to be a fatty central mass covered by normal-appearing skin from which numerous long black hairs grow. Within the center there are several hard calcified tooth structures and along one border is a slit-like area very much resembling eye formation with normal upper and lower lids, no lens can be found on sectioning the structure however.

Sections through the epithelial mound shows a thicker stratified squamous epithelial with a rather prominently pigmented basal layer beneath which there are an abundance of large sebaceous glands, numerous hair follicles and sweat glands. Beneath the glandular level the bulk of tissue is made up of fat. No cellular elements can be found within the fat. Only dermal elements are seen."

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"Do You Know That?"

If the following items were purchased in Civilian Pharmacies in this area, the average cost to the individual for the quantities indicated, would be:

APC----1 dozen 25¢  
2 dozen 45¢  
Sulfadiazine Tablets----1 tablet 05¢  
Multivitamin Tablets----100 tablets \$3.59  
Neosynepherine Nose Drops----1 ounce \$1.00  
Benadul Capsules----each 04¢  
Pyrazepam Tablets----100 tablets \$4.25  
Cold Capsules (Plain)----12 Capsules \$1.00  
Cold Capsules (Compounded with Codeine)--12 capsules \$1.25

Elixir Terp Hydrate with Codeine----4 ounces \$1.00  
Aluminum Hydroxide Gell----1 pint \$1.49  
Aureomycin----16 capsules \$12.50  
(less than 16)----each \$1.00  
All Ophthalmic Solutions----1 ounce - not less than \$1.00  
Special Cough Mixtures----4 ounces \$1.25  
Injectable Pencillin----1 dosage (300,000 Units) \$5.00



# DENTAL SERVICE

## INSTRUCTIONS FOR DENTURE PATIENTS

Reproduced below is the instructions given to prospective denture patients by the dental clinic, General Dispensary, USA, The Pentagon.

First you must realize that health conditions compelled the loss of your natural teeth; and that being toothless is better than being sick.

We believe that artificial teeth, as compared to a perfect set of natural teeth, are only 25% efficient. However, prosthetic or artificial teeth look and function far better than any other prosthetic or artificial restorations about the human body.

Your first impression is that of mouthfulness; this will disappear with constant wearing of the dentures.

You will experience at first an unusual activity on the part of the salivary glands, amounting sometimes to actual drooling, mouth continually filling with saliva. For years your salivary glands have been trained to pour out their secretions whenever solids are put into the mouth; now your salivary glands do not know that your dentures are not food but will find it out, after a few days of constant wearing. To overcome this it will require frequent swallowing for the first few days, usually about four days. You have been without teeth for sometime and no doubt have visions of enjoying a nice juicy steak with relish and comfort. CAUTION. GO SLOW. It is not yet time for the steak. Twenty miles per hour for the first five hundred is the wise rule to follow in breaking in new machines.

To begin with, eat soft foods taken in small portions. There is no need of your being discouraged by early failure. Remember that after the period of accommodation is past most people wear dentures with comfort and enjoy life and are happy that they possess them.

For the first month wear your dentures night and day, resting the mouth by removing them for one hour just before bed time, then at bed time replace them in your mouth. At the end of one month your dentures are well moulded to your mouth tissues. From now on remove them at bed time placing them in a glass of salt water, teaspoonful of common table salt in glass of water. Sleeping with dentures out of mouth after the first month gives the tissues a rest, and keeps the mouth in a more healthy condition. However, we have patients who claim they rest better at night by leaving their dentures in the mouth. If you find that this is your experience, then we advise that sometime during each twenty four hours you rest your mouth tissues by removing your dentures for at least 2 or 3 hours, preferably just before retiring.

Wash your dentures with soap and water (never hot water) for you may warp the acrylic part of your dentures. A five or ten cent hand scrubbing brush makes a good denture brush. Wash your dentures after each meal, and rinse mouth with warm salt water.

During the first few weeks there will develop sensitive spots, due to sharp points of bone pressing against the denture base. It is sometimes necessary for the dentist to grind out those spots on the dentures. The mouth or foundation for your dentures is changing to some slight extent all the time. In other words the bones forming the jaws are getting smaller (resorption of bone is taking place). This resorption reaches its maximum in most mouths at the end of one year. At that time your dentures may be too loose to be worn with comfort. This condition can be corrected by relining the dentures. After the first relining the resorption of your jaws is so little that you may never need a second relining.

Do not attempt to adjust or trim your dentures yourself, they may be ruined by faulty trimming.

In the beginning, return often to your dentist for adjustments. If a sore spot develops do not remove the denture to allow to heal, go immediately to your dentist. By so doing he can see the irritated spot and make a correction. It might be due to over extension of the denture sides or to the uneven striking of the teeth or a little splinter of bone coming through the tissues.

At first, you will be apprehensive about your dentures dropping out, you will have a tendency to talk through your teeth, try and overcome this early. Seat them well on the ridges and



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## DENTAL SERVICE

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make a special effort to speak freely with the jaws separated just as you did with natural teeth. Do not worry about your upper denture dropping down; if it drops push it back up with the tongue and if necessary place your thumb in the center of the vault and force the denture firmly into place. In bringing your teeth together do not reach forward with the lower jaw, always center your jaws by closing on the back teeth. Same applies in eating with dentures, its just the reverse to that of natural teeth, when you want to bite through food, bite with the lower jaw as far back as it will go, and incise the teeth at the angle of the mouth, not on the front teeth. If you do attempt to bite through food with the front teeth, say an apple, push the apple against the upper teeth in a vertical direction. If you reach forward with the lower jaw you will tip the lower denture. Avoid developing nervous habits of tongue pushing or muscular throwing of dentures, or that of gritting or grinding the teeth when not eating.

In placing the dentures in your mouth execute a half circle, starting with lower first. Hold it so that its side is parallel with your lips, passing the right heel of the denture close to left angle of mouth in a diagonal line over against the far back end of your right lower ridge (jaw). The same method applies for the upper denture as well, where it is modified a little depending upon the individual's mouth conformation, wherein there is a heavy ridge of bone that requires careful passing over. This rotating method of placing your denture permits of the minimum amount of opening of the mouth which is a help, in that it relaxes the facial muscles, which are stretched over the ridges when the mouth is opened widely and prevents you from seating the dentures upon their respective ridges.

Your dentures for many reasons permit of only a functional range of jaw movement, when you exceed that limit you are necessarily going to experience difficulty. For instance, when you open your mouth to the limit (which by the way is never necessary in the pursuit of life and happiness) you place muscles under extreme stretch and by so doing lift your lower denture up off its seat and in some cases the upper denture will be unseated also.

The carpenter wearing dentures can blow saw dust from his work without misplacing his dentures by proper muscle control; that is, he does not inflate his cheeks with air, but holds his cheek muscles taut and keeps his jaws fairly close together.

These problems are brought to your attention to remind you that nature permits you this second chance through a denture compromise. That dentures are truly a compromise between nature and the patient, between patient and dentist, between esthetics and mechanics, and between varying factors found in each individual case.

A word to denture patients concerning cancer. We do not know of a case of cancer developing from properly fitting dentures.

You are advised not to attempt eating hard or tough foods until your gums or tissues are accustomed to carrying their unnatural load. Until such time you should eat soups, eggs in any form, well cooked cereals, stewed fruits, fresh fruits, prepared in small pieces, well cooked vegetables, mild toast and soft desserts. This diet will provide you ample nourishment until you are qualified to join the class of steak eaters.

In some mouths a grayish deposit of calculus (stone) forms upon the dentures. This can be buffed off or carefully scraped off in many ways. One should avoid scrubbing dentures with abrasives as they remove the polished smooth surface, which when lost makes it more difficult to keep dentures clean.

As a last word, bear in mind that a determined effort in the beginning is the requisite to future denture comfort.



# VETERINARY SERVICE

## ICE CREAM

### Classification of Ice Cream

Plain ice cream--Plain ice cream contains a standard percentage of milk fat and is flavored with vanilla, caramel, or mint and some chocolate. Various states specify milk fat standards and some mention nonfat milk solids and stabilizers.

Fruit ice cream--Fruit ice cream usually contains 1 or 2 percent less milk fat than plain ice cream with a variable amount of fresh, frozen, or preserved fruits such as strawberries, raspberries, peaches, apricots, pineapple, or raisins.

Nut ice cream--Nut ice cream contains from 1 to 2 percent less milk fat than plain ice cream and varying amounts of nuts and added flavors.

Bisque ice cream--Bisque ice cream, in addition to a higher percentage of milk fat (16 to 20 percent), contains either some baked product such as bread or cake, or confections such as macaroons or marshmallows.

Parfait--Parfait is an ice cream, which in addition to being rich milk fat, contains eggs and sometimes fruits or nuts and other flavors.

Puddings--Ice-cream puddings are ice creams of high milk fat content and contain eggs, nuts, and assorted fruit.

Aufait--This is a brick ice cream consisting of layers of one or more kinds of ice cream with solid layers of frozen fruits between.

Fancy molded ice cream--Molded ice cream is softened bulk ice cream molded in special containers in various shapes, such as animals, flowers, or fruits. After rehardening, the ice cream is removed from the mold and decorated.

Ices--Ices are frozen products made from water, sugar, fruit juices, and stabilizers.

Sherbets--Sherbets are similar to ices but contain in addition skim milk, whole milk, or 10 percent ice-cream mix.

### General Points of Consideration

Grading--Ice cream is not graded and sold on the market by grade as are butter and cheese. The ice-cream manufacturer judges his own product. Score cards are often used in evaluating the quality of ice cream, numerical scores being given for flavor, body, texture, appearance, and package.

Flavor--The flavor of ice cream is largely influenced by the quality of the dairy products used in its manufacture. Metallic, old-cream, rancid, bitter, stale and cooked flavors are usually due to the use of poor quality dairy products. The use of too much or too little flavoring, or flavoring of poor quality, causes flavor defects.

Texture--"Body and texture" is often referred to as a single quality. The body refers to the whole structure of the ice cream and is largely influenced by the composition of the mix, whereas the texture has to do with individual particles which forms the entire body. Body and texture defects may result from poor quality ingredients and inferior methods of processing and freezing. The ice cream produced may be fluffy, weak, crumbly, watery, icy, soggy, and gummy.

Bacteria--Low temperatures during storage protect ice cream from bacteriological deterioration. However, it is very important to use high quality products with low bacterial counts in the preparation of an ice-cream mix. Under proper conditions, it is possible to prepare commercial ice-cream mixes with bacterial counts under 100,000 per milliliter. The ice-cream maker's chief concern in regard to bacteria is from the standpoint of health. The ingredients used or the finished mix may become infected with disease-producing organisms upon which the cold temperature will have no effect. Pasteurization of the ice-cream mix, careful cleaning and sterilization of the equipment, and supervision of the health of the employees will largely eliminate these dangers.



# NURSING DIVISION

## WHAT IS CANCER? 1st. Lt. Marie V. Hontz, A.N.C. Station Hospital Fort Belvoir, Virginia

As a part of our staff educational program a film was shown entitled "What is Cancer?" This film was procured from the Virginia Division of the American Cancer Society.

The mortality rate from cancer is too high. Nurses need a definite knowledge and understanding of the disease in order to help combat it. Early diagnosis is extremely important, for malignant tumors have uncontrolled growth, spread through the body and have the power to kill if not treated adequately and in time.

The film opened with an historical sequence followed by an overall statement of the cancer problem. One gets a clear picture of the danger points. The digestive system, the skin, the breasts and the genitalia are the common sites of cancer. Cancer of the stomach causes the greatest number of deaths.

Cancer can originate anywhere in the body. Growth is brought about by a process called cell division or mitosis. One cell divides to make two cells; these two new cells divide to make four cells, and so on. This is what happens when everything is under control. Now when the cells rebel against the law of growth, they suddenly start to divide in an abnormal and unruly fashion-become outlaws-run wild. After a while a lump of cells is produced which has no useful function. This lump is called a tumor. Cancer cells multiply continuously and spread rapidly. As it grows, it destroys neighboring healthy cells by robbing them of their blood and food supply. After a cancer has grown locally for awhile, some of its cells may break off and be carried by the lymph and blood to other parts of the body. Wherever these cells lodge another cancer starts to grow, so keep in mind the fact that cancer is a local disease at the start, and unless these cells are removed by surgery or destroyed by radiation they inevitably kill the patient.

Certain chemicals, known as carcinogenic substances, produce cancer in laboratory animals. The film vividly presented this reaction on a mouse. Physical conditions on clinical cases were shown as predisposing to cancer.

These facts, plus the seven danger signals by which patients themselves can recognize the disease, complete the basic description of what cancer actually is.

Cancer is always an emergency, and the danger of metastases is emphasized. A comparison of primary and metastatic lesions of the breast is shown as well as treatment by radio active isotopes which are sometimes given when thyroid cancer has spread.

The film then shows the effectiveness of early treatment. Radium, X-Ray, and surgical procedures for cancer are all shown. We are also shown the post-operative care needed by some patients.

A description of the palliative value of hormone therapy is given. It is especially used where treatment of the disease by radiation and surgery is no longer possible or profitable.

Nurses are reminded that cancer is now the second most frequent cause of death. They must be alert in the direct contacts with patients in the doctor's office, the plant examining room, or the home if they are to help control and fight cancer.

The observant and alert nurse can often persuade a patient to seek treatment or can elicit valuable information about symptoms.

An important phase in the pre-operative or post-operative situation is the psychological support that frequently can be given, not only to the patient but to the family. A healthy mental attitude can be created and preserved.

In closing, the film depicts the nurse as a part of the doctor-patient team in the fight against cancer. She has the training to apply her highly developed skills to the conquest of a

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dreaded disease and a great opportunity to help the patient psychologically.

## References

Reprint from American Journal of Nursing. Vol. 49. No. 5 - What is Cancer? Marjorie E. Schlotterbeck. R.N.

There is Something You Can Do About Cancer. Pamphlet-Metropolitan Life Ins. Co.

Who, What, Why, Where, When of Cancer. Pamphlet, American Society of Cancer.

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## SIGHT CONSERVATION PROGRAM

Progressive steps are being taken currently to conserve sight at the Army Map Service. During a recent test a sample screening of 921 employees were examined with the Telebinocular instrument. Of this amount 323 employees or 35% of those tested were found to have less than 20/20 vision in one or more of the eight separate tests prescribed. In each case of visual deficiency the employee was informed of the particular defects and advised to have a complete examination by an ophthalmologist. In this way their vision may be brought to the highest level possible.

These tests were made on a voluntary basis and averaged about six minutes for each test. Only those employees entirely dependent on good vision for proper performance of their assigned job were offered the test because the machine was borrowed for a limited time for this test sampling.

These tests were recorded in such a manner that information is available by age, sex, department and whether or not glasses were used at time of tests. The individual records will be on file for future reference at any time by the employee concerned.

A retest at six month intervals is expected to improve the general eye condition and stimulate much interest from an employer-employee morale viewpoint. The program was received with much enthusiasm by all concerned.

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Reproduced from the "Second Report of the Secretary of Defense", page 53, is the Scientific Research and Development dealing with The Medical Sciences:

"Jet propulsion and atomic weapons are representative of new elements in modern warfare which have created special problems for military medicine. Current research includes such varied subjects as aeromedicine, rescue and survival in emergencies, effects of environment on health and efficiency, infectious diseases and preventive medicine, and general medicine and surgery.

In aeromedicine, studies are being made to determine the potential physical forces involved in crashes and the physiological tolerances of the human body to extremes in acceleration and deceleration; to elucidate and protect against the forces to which aviators are subjected in high-speed, high-altitude flight, as well as to solve problems of escape from high-speed aircraft; and of minimization of physiological effects of noise and vibration. Among the special studies to improve the operational efficiency of fliers are investigations of the visual function, including depth perception, color vision, night vision, and facility in reading signals and instrument panels.

Research relevant to radiation injury includes: the value of administering concentrated white blood cells in radiation injury and the effect of pituitary extracts on local radiation injury. The discovery of a dye which makes possible differentiation between living and dead or dying cells is a research tool of great value in studies of radiation injury and wound healing.

In the field of infectious diseases and preventive medicine, investigations are continuing on the use, limitations, and appraisal of new drugs and vaccines and on better methods for the prevention and control of localized infections. In general medicine, studies are being made on such diverse problems as the use of bacterial enzymes in the treatment of certain medical and surgical conditions; control of pain by new chemical agents; causes of anesthetic deaths; and the role of hemoglobin of transfused cells in regeneration of recipient red blood cells."



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# PREVENTIVE MEDICINE

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## PERSONNEL ADJUSTMENTS AND PERSONAL HYGIENE

### Malassignment

The most common problem is malassignment of personnel. The officer has to discuss this frankly with all concerned, and point out that the main aim of the Army is to find fighting men to win the war; that there is a limited number of types of jobs; that there is a different ratio of particular types of jobs in the Army as contrasted to those in civilian life; and the necessity for certain fundamental and basic training of all soldiers, regardless of their jobs. The company commander must know the administrative techniques for transferring a man. It is possible for the soldier to be malassigned. Failure to find the right job may lead to dissatisfaction on the part of the man, with eventual refusal, AWOL or a neuropsychiatric casualty. The officer must answer these questions for each man: "What has the enemy done to others and what do they intend to do to me?"; "Why do we as a nation fight?"; "What is the job of our outfit?"; and "What is my job and why?"

The American soldier identifies himself rapidly with his immediate group, the platoon, or company. He makes friends within it; he suffers its hardships and benefits by its privileges. Practically every soldier develops an attachment to a buddy, a relationship which sustains him in danger and gives him his first lessons in group activity and individual sacrifice. Buddies are often killed, however, and more often wounded or removed from the scene in other ways. In this case, the soldier who has no broader ties finds himself lacking support and is very likely to develop great anxiety. To some extent the same is true of those men who have developed a firm attachment only to their companies. So long as the company remains a unit, they have something to sustain them; when it is decimated in combat, or when they are separated from it by wounds or illness, this attachment, too, loses its value. Because of this, there has been a very definite attempt to teach a wider range of identification, to include the regiment, division, and army, units which are indestructible. This has value in proportion to the size and permanence of the unit; and it has been successfully fostered by such methods as distinctive insignia, newspapers, and rest camps. Underneath all this is the need to have the soldiers regard this group, whatever its size, as powerful enough to accomplish its mission, to protect him, and to appreciate him. He must feel that the mission is important and that it can and will be carried out. It must be remembered that in inculcating a wider range of identification for the soldier, the epigram, "a chain is no stronger than its weakest link," must be impressed on the mind of the soldier.

### AWOL

The most important factor concerning the AWOL is the absence of a sense of duty and responsibility to the service. There are many reasons why a soldier will go AWOL. First, we find soldiers who, for some reason have not developed a mature personality, judgment, or the sense of duty necessary to understand the full meaning of army responsibility. This occurs particularly in young soldiers, frequently those who enlisted for the desire for a thrill and new experience but with little appreciation of the seriousness of the duty that they were undertaking.

There are also individuals who, throughout their lives, have never been required to exercise any degree of discipline or control over themselves. Of this group it can be said, however, that many make good soldiers, with help. An understanding talk on the real meaning of military responsibility, with accompanying, but not excessive, disciplinary action, will often be of help. Such counseling may sometimes be given effectively by the company commander himself. The second group of AWOL's comprises those soldiers who tend to resist all authority. These men generally have had similar problems in their civilian lives. Among these are also the individuals who seek to avoid or to run away from an uncomfortable experience, especially if it gives rise to fear. They include, for example, the soldier who may have reacted on the spur of the moment against an order or who, having been denied a pass, takes it into his head to walk off the post. This group of problem soldiers presents a more serious question as to their usefulness in any position in the military service. Disciplinary action alone does not usually improve their behavior, because of the fact that they go AWOL without thought of consequence, although as far as they are concerned, they have a very good reason. These soldiers require study by a specialist to determine the degree to which they might be helped to overcome their problem and to make a good adjustment, or to decide whether they are a total military liability.

The third type of AWOL, somewhat similar to the second, are those who have no moral sense

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## PREVENTIVE MEDICINE

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of responsibility whatsoever. These are men who frequently have long civilian court records and who have been engaged in delinquencies and perhaps crimes for many years. They believe only in standards they set for themselves, and cannot be aroused to a feeling of duty or guilt over their misbehavior. They are nonchalant and pleasant in their outward manner, as long as they are not asked to do anything that they do not want to do. Alcoholism is a frequent symptom in this group. Among this group may be found the majority of deserters. It is frequently necessary to discharge this group of AWOL's because they cannot be rehabilitated or affected by discipline or guidance in the military setting. If allowed to continue in the service, they will be a continual detriment to their unit, since they cannot be trusted or depended upon. They quickly cause a lowering of morale among their comrades.

A fourth and rather frequent reason given for being AWOL is encountered among those soldiers who have personal problems outside of the Army; it may be the birth of a child, the illness of a member of the family, concern over a girl friend, or worry over any one of many other civilian ties from which the soldier has not been able to make a separation. In this group we find soldiers who have been closely tied to their homes and who have never developed a mature sense of independence. They will often use some tie with the outside as a reason for being AWOL, when actually this is their excuse for avoiding the hardships of military life. In most instances, it is possible to determine the exact nature of their problem; and by utilizing the proper resources within the command, such as the Personal Affairs officer, they can be greatly assisted in developing a conscientious allegiance to their job. Agencies such as the Red Cross can be called upon to render practical aid and assistance to the soldier in helping him with his extra-military or civilian problems and maintaining contact between him and his family.

Because of the relatively high percentage of serious problems found among AWOL's and deserters, it would be advisable for the company commander to refer those who go AWOL frequently to a military psychiatrist, if for no other reason than to determine their mental responsibility and to give the company commander information as to whether these men may now or later present a serious problem to the service.

### Peculiar Behavior

The most difficult group of problems to describe are those which generally may be included under this heading. The phrase "peculiar behavior" is often used, and usually this is an indication that a more serious irregularity of personality is present.

The first to recognize "peculiar behavior" in the soldier would naturally be the group of men with whom he lives. He may be considered "goofy" by his associates, the butt of jokes. He may do many odd things, such as washing his hands continuously, or show marked lack of personal cleanliness, odd body movements, and unusual posture. He may be considered absent-minded, preoccupied, gullible. He may have peculiar manners while eating or have extreme difficulty with simple tasks as making a bed, sweeping, or clothing himself. On the other hand, he may talk about hearing voices, seeing things, having peculiar body sensations or wild ideas.

Peculiar behavior includes all strange conduct that appears rather far out of line with what the average individual reasonably does. As stated above, in any group of men such an individual will easily be noticed. He may come to the attention of the noncommissioned officer very easily in his (the NCO's) contact with the groups; very often, because of his actions he becomes the butt of jokes and ridicule on the part of the other men. Whenever any of these symptoms are observed, the company commander should waste no time in getting the soldier to a medical officer, who is a psychiatrist.

### Gold-Brick

The soldier who is described as a gold-brick is not necessarily either a bad soldier or an intentional gold-brick. A gold-brick is one who pretends he is working or tries to make the impression that he is working. Gold-bricking may be the first sign of a nervous condition or of an emotional maladjustment, as well as the method some emotionally disturbed soldiers use in an attempt to make life easier for themselves in the Army.

First to be noted are the gold-bricks who are basically irresponsible persons. These are



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## PREVENTIVE MEDICINE

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the men who have found it possible to get away with things in civilian life, and who simply bring this kind of behavior with them into the Army. They usually respond to discipline and close supervision upon realizing that gold-bricking does not pay in the Army. When this type of soldier is questioned about his gold-bricking, he will usually give evasive, somewhat defiant, or facetious answers. His answers are usually different from those given by other types.

The second type of gold-brick is the one who has developed a specific resentment against the Army. He may resent the type of work he has been given and show his resentment by gold-bricking. Sometimes, a simple discussion with him about the way in which he was assigned his job, or a talk about its importance to the Army, or an evaluation of the job in a new way, may be all that is needed to straighten him out.

Another type is the soldier who opposes any authority. He may have been over-protected in civilian life and has not adapted himself to Army responsibilities, or he may be an emotionally disturbed person who cannot, without prolonged and professionally competent treatment, respond to authority. In any case, if gold-bricking is repeated after attempts to change the situation have failed, study and observation by professional personnel should be sought.

A fourth category is the type of soldier who resents the Army because it has separated him from his home and his loved ones and he cannot get along without them. He is unable to accept the Army as he finds it, and in this evasive way, through gold-bricking, he avoids his responsibilities. This type of soldier is in need of psychological guidance. A talk with him will usually reveal some childish feelings behind his behavior; here, again, professional judgment may be called on.

From the above, it will be seen that "gold-brick" is the name for soldiers who have a wide variety of difficulties in getting along in the Army. In this connection, the first job of the company commander is to attempt to get some ideas as to what is back of the behavior; then, finding that the situation may require intensive study he will refer the soldier to the psychiatrist who will deal with the soldier's problem as a whole.

### The Chronic Sick Caller

The soldier who goes on sick call with unusual frequency may do so because he is actually suffering from some physical ailment that requires prolonged treatment at the infirmary or station hospital, though it may not be severe enough to remove him from active duty; because his physical complaints do not respond to treatment or an organic basis for his complaints is absent; or because he is actually malingering. In the first instance, the company commander would be in position to help the soldier's treatment and complete recovery by consulting the medical officer and finding out how the soldier's ailment temporarily limits his ability to carry out certain duties. For example, the man who is being treated for some trouble with his feet might be given work that would not involve standing or walking until he recovers. This responsibility the officer would want to take, even if the soldier himself did not request any special consideration.

In the instances where a soldier does not respond to treatment, or where no physical basis for his complaint is found, the officer can not afford to ignore the fact that the soldier complains. Any attempt to force a soldier to stop his complaints might only result in his expressing his difficulty in other ways, such as disobedience of orders, refusal to do work assigned, unauthorized absence from drill, poor school work, or even going AWOL. The company commander must bear in mind the fact that modern psychiatry knows that a person may feel real aches and pains for which no physical basis can be determined.

# ADMINISTRATIVE DIVISION

## NOMENCLATURE AND DEFINITIONS PERTAINING TO FIXED MEDICAL TREATMENT FACILITIES

Quoted for information and guidance is AG Letter, file AGAO-S 427 (17 Feb 50) MEDCA-M dated 1 March 1950:

"Bed capacities and status reported by installations and activities on or after 1 April 1950, will be in conformity with the nomenclature and definitions contained in the following memorandum from the Office of the Secretary of Defense, 27 January 1950. Instructions relative to the new reporting procedures will be disseminated in the near future.

'In order to effect more uniformity in the nomenclature and definitions used in the Department of Defense with respect to fixed medical treatment facilities, it is the policy of the Department of Defense to use the following nomenclature and definitions with reference to the capacities and the 'bed status' of such facilities:

'With respect to 'capacities' of fixed medical treatment facilities:

'MOBILIZATION BED CAPACITY is space for patients' beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds, spacing beds six feet between centers (approximately 72 square feet per bed). Former ward space which has been disposed of, or has been structurally altered to serve another purpose is not included in computing bed capacities. Space for beds used only in connection with examination or brief treatment periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity, but is accounted for separately in terms of the number of bassinets it accommodates.

'NORMAL BED CAPACITY, or capacity for normal peacetime use, is space for patients' beds, and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds, spacing beds eight feet between centers (approximately 100 square feet per bed). Former ward space which has been structurally altered to serve another purpose is not included in computing bed capacities. Space for beds used only in connection with examination or brief statement periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity, but is accounted for separately in terms of the number of bassinets it accommodates.

'With respect to the use being made of the above 'bed capacities' of fixed medical treatment facilities (i.e., as to the availability of beds set up and as to the status of the remaining spaces for beds):

'OPERATING BEDS are those medical treatment facility beds which are currently set up and in all respects ready for the care of patients and which the facility is staffed and equipped to operate. Bassinets for the use of newborn infants in the nursery are not included in the count of operating beds, but are accounted for separately.

'OCCUPIED BEDS, is the number of operating beds in a medical treatment facility which are currently assigned to patients. It does not include any beds for patients who are on leave or absent without leave.

'OPERATING BEDS AVAILABLE is the number of operating beds in a medical treatment facility which are not currently assigned to patients.



## ADMINISTRATIVE DIVISION

'INACTIVE BEDS are those medical treatment facility bed spaces with beds, not necessarily set up, for which equipment and fixtures are on hand and installed, but for which operating staff is not provided. Inactive beds may be converted to operating beds within a day or two after the necessary staff is made available.

'LATENT RESERVE BEDS are those medical treatment facility bed spaces for which are lacking not only the required staff but also some or all of the equipment and fixtures necessary to convert them to operating beds. Maintenance repairs may be required to effect this conversion. The time required to convert latent reserve beds to operating beds will vary and may be prolonged.

"It is intended that a fixed medical treatment facility operating with beds set up on eight-foot centers (approximately 100 sq. ft. per bed), will also count inactive beds and latent reserve beds on this basis. Thus, when no space is being counted by mobilization capacity criteria, the sum of the operating beds, inactive beds, and latent reserve beds, is equal to the normal bed capacity. A fixed medical treatment facility currently authorized to set up operating beds on six-foot centers (approximately 72 square feet per bed), will count inactive beds and latent reserve beds on the basis of six-foot centers (by mobilization capacity criteria), and also on the basis of eight-foot centers (by normal capacity criteria)."

"The above seven (7) terms for standard use throughout the Department of Defense will supplant the larger number of non-standard terms of this nature heretofore variously used. The use of terms having indefinite or not uniformly understood meanings, such as maximum capacity, constructed capacity, emergency capacity, authorized capacity, beds assembled and beds vacant, will thus be obviated'."

Section I, SGO Circular 22, 1950, is rescinded.

\*\*\*\*\*

Attention is invited to the provisions of SR 40-320-5, dated 21 February 1950, dealing with Inspection of Certain Parenteral Solutions. Pertinent provisions of this SR are reproduced herewith for information and guidance for all concerned.

"1. Causes of deterioration.--a. The storage life of dextrose, sodium chloride isotonic solution, and water for injection is limited by the corrosive action of the solution upon the glass container and mechanical faults in the rubber closure which may be present in a small number, initially, or which may develop upon aging. Corrosion of the glass surface around the rubber stopper, which will permit the entry of air and the eventual contamination of the solution with atmospheric micro-organisms, which is usually indicated by the presence of readily visible mold growth or turbidity.

b. The appearance of a significant percentage of deterioration in the above solutions occurs following prolonged storage. Storage under tropical conditions accelerates the deterioration. An investigation is being conducted to determine the age and status of deterioration of depot stocks, in order to eliminate, to the greatest practicable extent, the possibility of issue of deteriorated solutions.

2. Inspections.--a. Since deterioration may occur while in station stock storage, and since even fresh solutions may occasionally be contaminated because of accidental mechanical faults in the closures, supply officers at Army stations will inspect solutions for turbidity, prior to issue. Solutions for parenteral use must be clear and free from turbidity or undissolved material. This turbidity or undissolved material should be detected without magnification when the solution is examined against black and white backgrounds using a bright light reflected from a 100-watt Mazda lamp or its equivalent. All solutions should be examined in this manner at stations prior to issue. Solutions on which lot number and dating have been obliterated from the container must not be issued for parenteral injection.

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## ADMINISTRATIVE DIVISION

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b. To insure further a clear solution and avoid reactions, inspection by reflected light should be made again immediately before administration. Gentle swirling or careful inversion of the container may be necessary to bring particles within the field of vision. Fine air bubbles, which may be entrained during manipulation, may be recognized by the spherical or oval shape and movement toward the surface. Solutions showing evidence of contamination must be discarded."

\*\*\*\*\*

Attention is invited to Circular 5, Department of the Army, 30 January 1950, regarding DD Form 251, Council Book. This circular states "DD Form 251 will not be requisitioned, issued, or utilized until all available stocks of DD AGO Form 10-4 (QMC Form 15) are exhausted."

\*\*\*\*\*

Reproduced from the "Report of the Secretary of the Army", page 162, is a paragraph dealing with The Army Medical Department.

"During the past fiscal year the Medical Department contributed materially to the development of several important new drugs for the prevention and cure of certain illnesses. Chloromycetin and aureomycin, which in their natural form proved effective in combating the rickettsial diseases and typhoid fever, were discovered to be equally useful when synthesized chemically. Dramamine, a promising new remedy for sea-and air-sickness, was subjected to thoroughgoing tests with, on the whole, favorable results. Experiments also disclosed that blood plasma could be used without the serious danger of transmitting infectious hepatitis if the plasma was treated by irradiation to destroy the virus of that disease."

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## OUTPATIENT SERVICE

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### OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed General Hospital, are indicated below for the four Week period ending 24 February 1950:

#### ARMY:

Number of Outpatients. . . . . 5,856  
Number of Treatments . . . . . 15,980

#### NON-ARMY:

Number of Outpatients . . . . . 5,672  
Number of Treatments . . . . . 17,652

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED. . . . . 1,408  
NUMBER OF VACCINATIONS AND IMMUNICATIONS ADMINISTERED . . . . . 4,263

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## HOSPITAL MESS ADMINISTRATION

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STATION	November 1949	December 1949	January 1950	February 1950
FORT BELVOIR				
Income per Ration	\$1.066	\$1.038	\$1.052	\$1.057
Expense per Ration	1.082	1.083	1.119	1.039
Gain or Loss	-0.017	-0.045	-0.067	+0.018



## GENERAL COMMENT

The health of the command continued to be satisfactory.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and II installations exclusive of Walter Reed General Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of other service's medical installations is made. Air Force statistics are tabulated separately for units having Air Force personnel assigned. (See General Data and Admissions Tables on page 14.

The non-effective rate rose considerably over the January rate of 6.81 to 14.48 for the month of February 1950. Days lost as a result of disease and injury totalled 7020 during the four-week period ending 24 February 1950, a decided increase over the 3407 total days lost reported in January.

The total admissions for diseases and injuries in February were 882. Of this number 825 admissions were for diseases and 57 for injuries. The 882 admissions for all causes (diseases and injuries) during the report period were a decided increase from the 557 cases of the previous month. The rate for February is 664.0; January's rate was 406.4. South Post, Fort Myer reported the lowest rate with 365.2 and Fort Myer the highest with 1035.5.

February's rate for disease cases is 621.1 for 825 cases. The lowest rate for the admission of diseases was reported by South Post, Fort Myer; the highest was reported by Fort Myer. The former rate being 365.2 and the latter being 965.9.

The incidence of injuries continued on a downward trend during February with a rate of 42.9 for 57 cases. South Post, Fort Myer reported the lowest injury rate. (No injuries being reported by this unit during February.) Fort McNair for the past 2 months has reported the highest rate (the unit's rate this month being 163.9 for 11 cases).

No deaths were reported during the 4-week period ending 24 February 1950.

## COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of February 1950 with 167 cases reported with a rate of 125.7. January's rate was 88.3 for 121 cases. Fort Myer reported the highest incidence of respiratory diseases with a rate of 391.6. The lowest incidence was reported by Fort Belvoir with a rate of 31.3.

Admission rates for pneumonia all types continued to rise during February report period. The rate being 14.3 which may be compared with January's rate of 10.2.

No cases of measles, scarlet fever or malaria were reported throughout February 1950.

Mumps, tuberculosis, rheumatic fever, diarrhea and hepatitis reflected a slight increase over the number reported last report period.

Pertinent statistical tables may be found on pages 14 and 16.

# PREVENTIVE MEDICINE

**RESTRICTED**

## GENERAL DATA 4 Week Period Ending 24 February 1950 (Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Diseases		Injuries			
				Cases	Rate	Cases	Rate	Cases	Rate		
Fort Belvoir (A)	8323	7030	1293	503	787.8	482	754.9	21	32.9	17	0
(AF)	164	164	0	24	1907.6	24	1907.6	0	-	28	0
Fort McNair (A)	875	795	80	47	700.2	36	536.3	11	163.9	19	0
(AF)	94	94	0	0	-	0	-	0	-	0	0
Fort Myer, Virginia (A)	1498	1304	194	119	1035.5	111	965.9	8	69.6	15	0
(AF)	0	0	0	1	-	1	-	0	-	0	0
South Post, Fort Myer (A)	1606	1606	0	45	365.2	45	365.2	0	-	12	0
(AF)	0	0	0	0	-	0	-	0	-	0	0
General Dispensary, USA (A)	3436	3403	33	102	387.0	99	375.6	3	11.4	13	0
(AF)	3416	3392	24	100	381.6	98	374.0	2	7.6	11	0
All Others (A)	1576	1576	0	66	545.9	52	430.1	14	115.8	5	0
(AF)	52	52	0	0	-	0	-	0	-	10	0
Total Mil Dist of Wash (A)	17314	15714	1600	882	664.0	825	621.1	57	42.9	15	0
(AF)	3726	3702	24	125	437.3	123	430.3	2	7.0	11	0
AMC - Med Det (Duty Pers)*	1737	1594	143	49	367.7	49	367.7	0	-	5	0
AMC - Med. Hold Det.*	1389	1266	123	131	1229.4	122	1144.9	9	84.5	990	1
AMC - Total (Army)	2617	2379	238	150	747.1	141	702.3	9	44.8	397	1
AMC - Total (Air Force)	509	481	28	30	768.3	30	768.3	0	-	673	0
AMC - Total (A & AF)	3126	2860	266	180	750.5	171	713.0	9	37.5	413	1
Total Dept/Army Units	19931	18093	1838	1030	672.0	965	629.6	66	43.1	65	1
Total Dept/Air Force Units	4235	4183	52	155	477.1	153	470.9	2	6.2	90	0
* Army and Air Force personnel included											

\* Army and Air Force personnel included

## ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR 4 Week Period Ending 24 February 1950 (Data From WD AGO Form 8-122)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diar-rheal Disease	Hepa-titis	Malaria	Psychi-atric Disease
Fort Belvoir (A)	31.3	20.4	14.1	-	-	11.0	-	3.1	6.3	-	1.6	-	11.0
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort McNair (A)	149.0	-	-	29.8	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer, Virginia (A)	391.6	17.4	17.4	60.9	-	-	-	-	-	-	8.7	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
South Post, Fort Myer (A)	170.4	-	-	8.2	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
General Dispensary, USA (A)	189.7	15.2	15.2	64.5	-	15.2	-	-	-	3.8	-	-	-
(AF)	179.3	3.8	-	-	-	3.8	-	-	-	3.8	-	-	7.6
All Others (A)	173.7	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash (A)	125.7	14.3	11.3	20.3	-	8.3	-	1.5	3.0	0.8	1.5	-	5.3
(AF)	164.4	3.5	-	80.5	-	3.5	-	-	-	3.5	-	-	7.0
AMC - Med Det (Duty Pers)*	97.6	-	-	22.5	-	-	-	-	-	7.5	-	7.5	-
AMC - Det of Patients*	37.5	37.5	18.8	-	-	9.4	-	28.2	-	-	-	-	18.8
AMC - Total (Army)	74.7	19.9	10.0	10.0	-	-	-	10.0	-	5.0	-	5.0	10.0
AMC - Total (Air Force)	51.2	-	-	51.2	-	25.6	-	25.6	-	-	-	-	-
AMC - (A & AF)	70.9	16.7	8.3	16.7	-	4.2	-	12.5	-	4.2	-	4.2	8.3
Total Dept/Army Units	118.7	15.0	11.1	18.9	-	7.2	-	2.6	2.6	1.3	1.3	0.6	5.9
Total Dept/Air Force Units	150.8	3.1	-	77.0	-	6.2	-	3.1	-	3.1	-	-	6.2

\* Army and Air Force Personnel Included



# PREVENTIVE MEDICINE

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## VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington decreased slightly during the February report period.

The rate for February 1950 was 16.56, a decrease over the January rate of 23.35. A rate of 49.63 was reported by "All Others", the highest rate this group of units has experienced for the past two months.

A total of 22 cases were reported for the four week period ending 24 February 1950. Of this total 14 were reported by Fort Belvoir, 6 by "All Others", and the remaining 2 by Fort McNair, and South Post, Fort Myer.

During the report period, white personnel incurred 14 of the reported number of cases, with a rate of 11.61, and 8 were incurred by negro personnel, with a resulting rate of 65.18 per 1000 troops per annum.

Seven of the said number of cases were reported as syphilis, and 15 as gonorrhea.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (February) in addition to the rate per 1000 men per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 16, 17, 18 and 19.

### NEW VENEREAL DISEASE CASES - EXCL EPTS - DECEMBER 49, JANUARY 50, AND FEBRUARY 50

	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
STATION	DECEMBER 49	JANUARY 50	FEBRUARY 50	FEBRUARY 50
Fort Belvoir	13.70	42.42	21.93	1.68
Fort McNair	-	14.29	14.90	1.14
Fort Myer	-	-	-	-
South Post, Fort Myer	-	7.80	8.12	.62
General Dispensary, USA	-	3.75	-	-
All Others	-	7.91	49.63	3.81
Total Mil Dist/Wash Units	6.73	23.35	16.56	1.27
Army Medical Center - Total	12.42	10.26	9.96	.76
Total Dept/Army Units, Mil Dist of Washington	7.41	21.72	15.65	1.20

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# PREVENTIVE MEDICINE

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY  
MDW RATE PER 1000 TROOPS PER YEAR

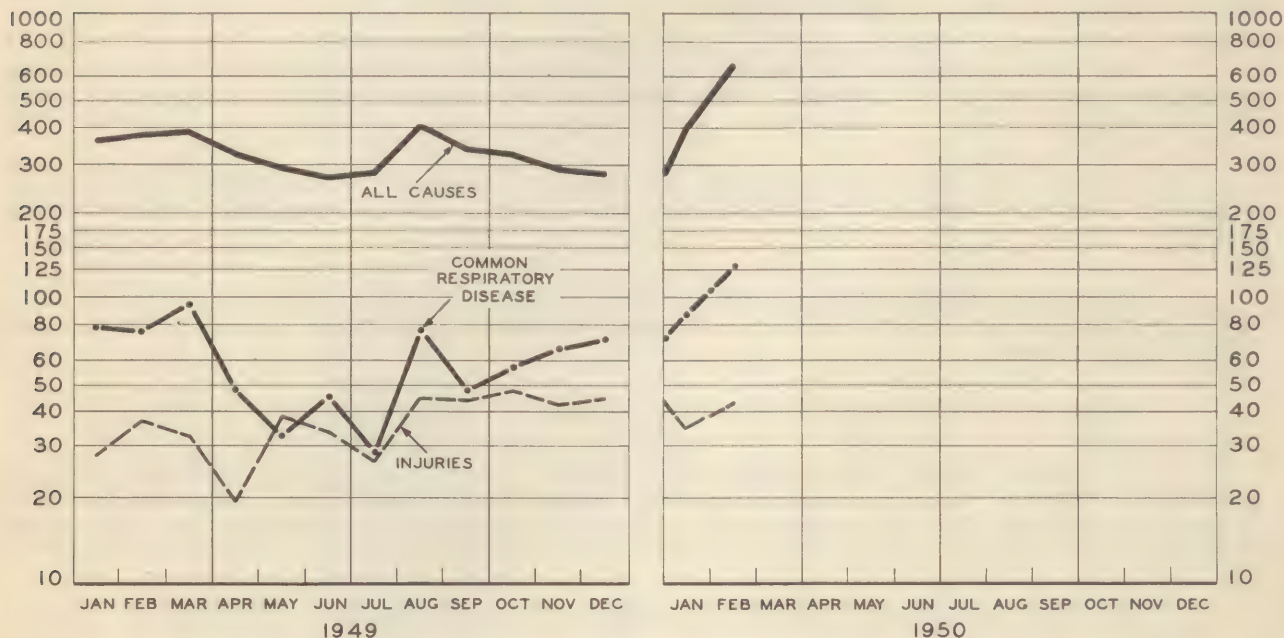
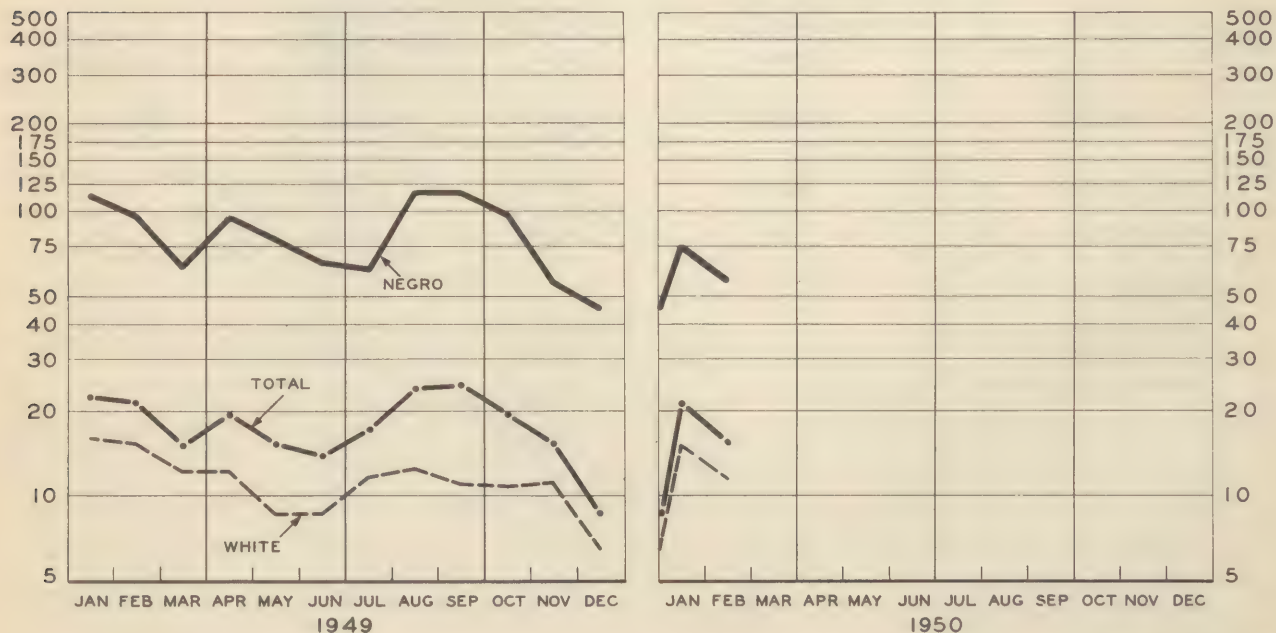


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER  
RATES PER 1000 TROOPS PER YEAR

INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



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# PREVENTIVE MEDICINE

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## CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Four Week period Ending 24 February 1950 (Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & new Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	7,030	1	6	0	7	12.98	1
	N	1,293	4	3	0	7	70.57	2
	T	8,323	5	9	0	14	21.93	3
Fort McNair	W	795	0	0	0	0	-	0
	N	80	1	0	0	1	162.94	0
	T	875	1	0	0	1	14.90	0
Fort Myer, Virginia	W	1,304	0	0	0	0	-	0
	N	194	0	0	0	0	-	0
	T	1,498	0	0	0	0	-	0
South Post, Fort Myer	W	1,606	0	1	0	1	8.12	0
	N	0	0	0	0	0	-	0
	T	1,606	0	1	0	1	8.12	0
General Dispensary, USA	W	3,403	0	0	0	0	-	0
	N	33	0	0	0	0	-	0
	T	3,436	0	0	0	0	-	0
All Others	W	1,576	1	5	0	6	49.63	0
	N	0	0	0	0	0	-	0
	T	1,576	1	5	0	6	49.63	0
Total Mil Dist of Wash	W	15,714	2	12	0	14	11.61	1
	N	1,600	5	3	0	8	65.18	2
	T	17,314	7	15	0	22	16.56	3
Army Medical Center - Total	W	2,379	1	0	1	2	10.96	113
	N	238	0	0	0	0	-	101
	T	2,617	1	0	1	2	9.96	214
Total Dept/Army Units	W	18,093	3	12	1	16	11.53	114
	N	1,838	5	3	0	8	56.74	103
	T	19,931	8	15	1	24	15.65	217

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# PREVENTIVE MEDICINE

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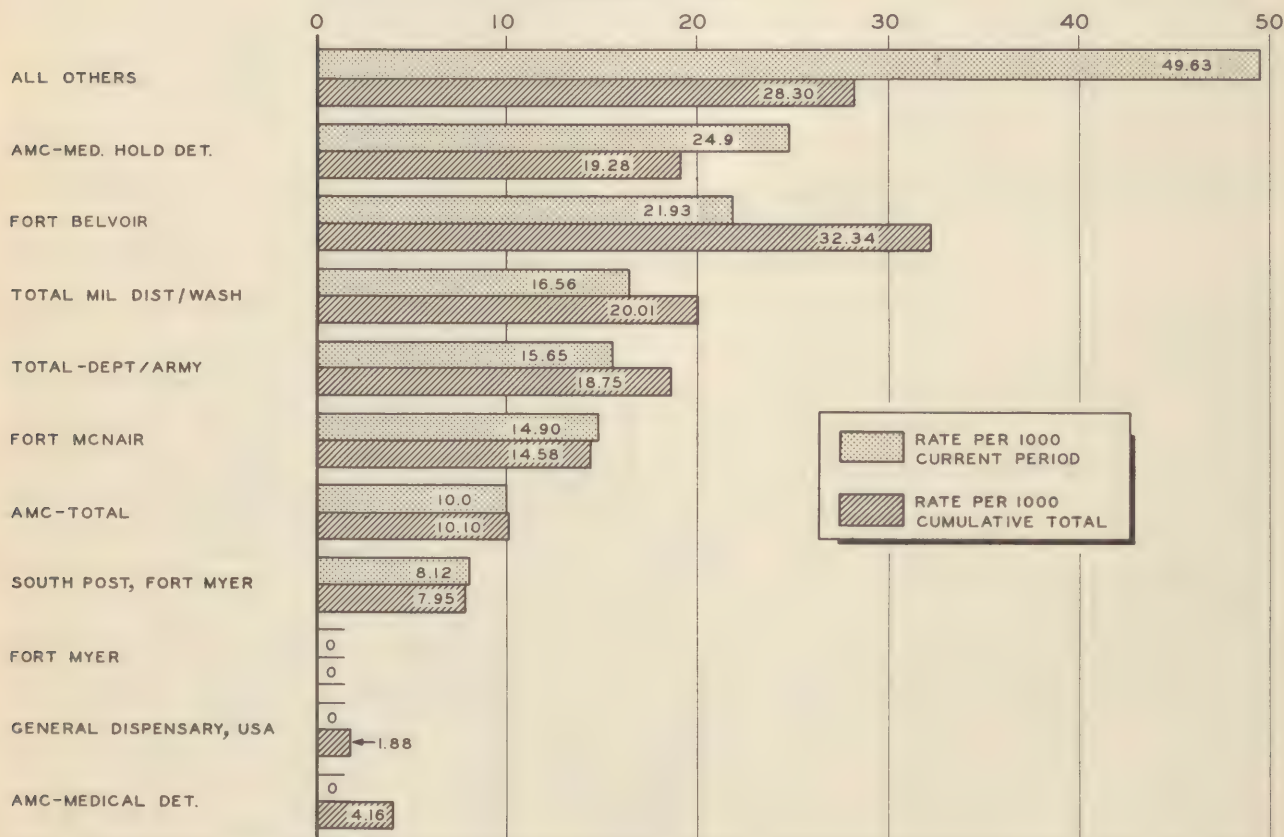
## VENEREAL DISEASE RATES FOR US\*

(All Army Troops)

	DECEMBER 1949	JANUARY 1950	FEBRUARY 1950
First Army Area	6	12	11
Second Army Area	12	19	21
Mil District of Washington	7	20	12
Third Army Area	18	26	22
Fourth Army Area	13	21	16
Fifth Army Area	9	16	15
Sixth Army Area	16	20	21
Total United States	13	20	18

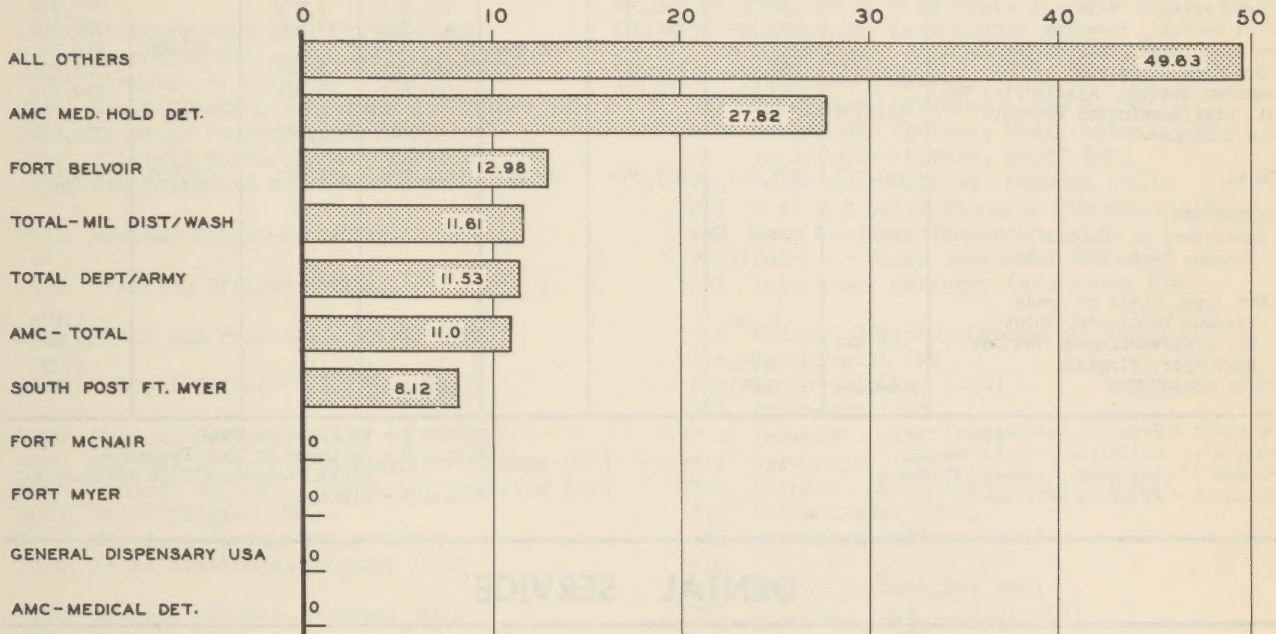
\* Compiled in the Office of the Surgeon General and includes General Hospitals.

## VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 24 FEBRUARY 1950 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)

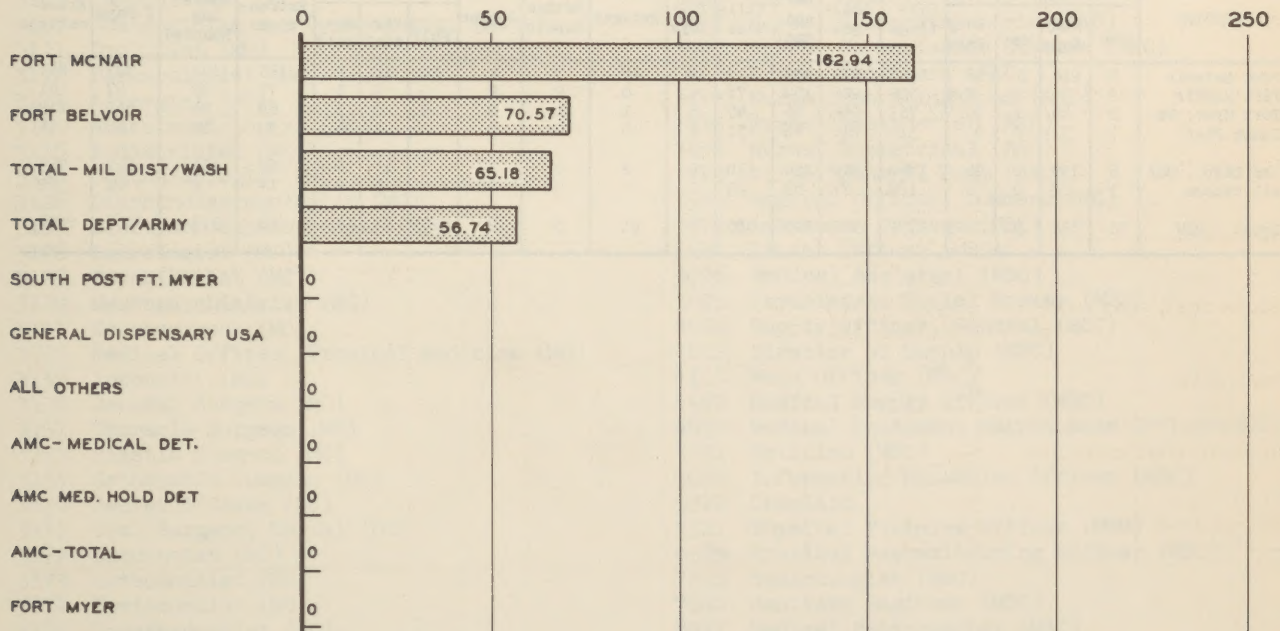




## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 24 FEBRUARY 1950 WHITE PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 24 FEBRUARY 1950 NEGRO PERSONNEL (CHARGEABLE CASES)



# VETERINARY SERVICE

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## POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED FEBRUARY 1950 - (Data obtained from WD AGO Form 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Leslie J. McNair		58,763	68,038		127,801	9,972		264,574
Fort Belvoir, Virginia		175,739	324,517		410,892	77,598		988,746
Potomac Yards Distribution Point		333,198	83,449	426,890			75,705	919,242
Fort Myer, Virginia		120,324	269,527	57	303,202	8,248		701,358
Cameron Station, Alexandria, Va.		89,383	69,534		165,811	4,519		329,247
Mil Dist/Washington Vet Det.	301,777							301,777
The Pentagon						254,428		254,428
TOTAL	301,777	777,407	815,065	426,947	1,007,706	354,765	75,705	3,759,372
REJECTIONS:								
Insanitary or Unsound								
Potomac Yards Dist Point		41						41
Not type, class or grade								
Potomac Yards Dist Point		1,192						1,192
Mil Dist/Washington Vet Det.	43,041							43,041
Fort Myer, Virginia		1,050						1,050
TOTAL REJECTIONS	43,041	2,283						45,324

\*Class 3 - Prior to Purchase

\*Class 4 - On delivery at Purchase

\*Class 5 - Any Receipt except Purchase

\*Class 6 - Prior to Shipment

\*Class 7 - At Issue or Sale

\*Class 8 - Purchase by Post Exchanges,  
Clubs, Messes or Post Restaurants

\*Class 9 - Storage

# DENTAL SERVICE

## DENTAL SERVICE - FOUR WEEK PERIOD ENDING 24 FEBRUARY 1950

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sil- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Removed	X-Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	8	216	1	18	1338	311	433	218	1	18	0	4	10	18	2	395	150	533	847
Fort McNair	2	33	1	7.5	316	208	159	78	0	0	2	2	0	2	5	17	32	97	41
Fort Myer, Va.	2	45	1	19	763	246	76	45	4	1	1	0	3	8	5	68	24	660	219
South Post	2	51	0	0	316	210	48	51	0	0	2	0	0	4	4	50	10	86	74
Gen Disp., USA	6	159	2	26	1860	519	150	170	0	2	0	3	5	17	18	68	163	662	765
All Others	1	28	0	0	189	77	59	23	0	0	0	0	6	5	0	14	0	29	92
Total - MDW	21	532	5	70.5	4782	1571	925	585	5	21	5	9	24	54	34	612	379	2067	2038

RESTRICTED



# ADMINISTRATIVE DIVISION

## MOS's AND TITLES THEREOF PERTAINING TO THE MEDICAL DEPARTMENT (Ref TM 12-406 and TM 12-425 A)

2110	Adjutant or Adjutant General (MSC)	3178	Dental Officer, Staff (DC)
2120	Administrative Officer (MSC)	3180	Physical Medicine Officer (MC)
		3182	Diagnostic & Therapeutic Radiologist (MC)
2200	Military Personnel Officer (MSC)	3184	Diagnostic Radiologist (MC)
2201	Personnel Assignment Officer (MSC)		
2205	Director of Personnel (MSC)	3200	Veterinary Officer, General (VC)
2210	Classification & Assignment Officer (MSC)	3201	Veterinary Officer, Large Animal (VC)
2231	Research Psychologist (MSC)	3202	Veterinary Officer, Small Animal (VC)
2232	Clinical Psychologist (MSC)	3203	Veterinary Officer, Staff (VC)
2239	Psychological Assistant (MSC)	3205	Veterinary Officer, Remount (VC)
		3221	Meat and Dairy Products Inspector (VC)
2431	Medical Registrar (MSC)	3222	Meat Products Inspector (VC)
		3223	Dairy Products Inspector (VC)
2520	Training Officer (MSC)	3231	Veterinary Officer, Laboratory (VC)
2616	Plans and Policies Officer (MSC)	3303	Medical Officer, Laboratory (MC)
		3306	Radiologist (MC)
2700	Student Officer (All Branches)	3307	Bacteriologist (MSC)
		3309	Biochemist (MSC)
3000	Medical Officer, Staff (MC)	3310	Parasitologist (MSC)
3005	Medical Officer, Preventive Medicine (MC)	3311	Serologist (MSC)
3006	Medical Officer, Industrial Medicine (MC)	3314	Clinical Laboratory Officer (MSC)
3007	Malariologist (MC)	3315	Entomologist (MSC)
3012	Hospital Administrator (MSC)	3316	Nutrition Officer (MSC)
3020	Vital Statistics Officer (MSC)	3318	Pharmacy Officer (MSC)
		3325	Tissue Pathologist (MC)
3100	Medical Officer, General (MC)	3327	Aviation Physiologist (MC)
3101	Medical Officer, Tuberculosis (MC)	3340	Optometry Officer (MSC)
3104	Proctologist (MC)		
3105	Gastro-Enterologist (MC)	3416	Occupational Therapist (WMSC)
3106	Ophthalmologist and Otorhinolaryngologist (MC)	3418	Physical Therapist (WMSC)
3107	Cardiologist (MC)	3420	Hospital Dietitian (WMSC)
3108	Obstetrician and Gynecologist (MC)	3430	Nurse, Administrative (ANC)
3111	Urologist (MC)	3437	Nurse, Neuropsychiatric (ANC)
3112	Dermatologist (MC)	3441	Nurse, Communicable Disease (ANC)
3113	Allergist (MC)	3442	Nurse, Pediatric (ANC)
3115	Anaesthesiologist (MC)	3443	Nurse, Operating Room (ANC)
3116	Pediatrician (MC)	3445	Nurse, Anesthetist (ANC)
3125	Ophthalmologist (MC)	3446	Nurse, Obstetrical (ANC)
3126	Otorhinolaryngologist (MC)	3449	Nurse, General Duty (ANC)
3127	Electroencephalographer (MC)	3500	Medical Officer, Command (MC)
3128	Neurologist (MC)	3503	Ambulance Officer (MSC)
3129	Psychiatrist (MC)	3504	Litter Officer (MSC)
3130	Neuropsychiatrist (MC)	3506	Medical Assistant (MSC)
3131	Neurosurgeon (MC)	3605	Psychiatric Social Worker (MSC)
3138	Medical Officer, Tropical Medicine (MC)	4000	Supply Officer, General (MSC)
3139	Internist (MC)	4012	Director of Supply (MSC)
3150	General Surgeon (MC)	4110	Mess Officer (MSC)
3151	Thoracic Surgeon (MC)	4490	Medical Supply Officer (MSC)
3152	Plastic Surgeon (MC)	4890	Medical Equipment Maintenance Officer (MSC)
3153	Orthopedic Surgeon (MC)	4891	Optician (MSC)
3170	Dental Officer (DC)	5004	Information-Education Officer (MSC)
3171	Oral Surgeon, Dental (DC)	5310	Chaplain
3172	Exodontist (DC)	5521	Physical Training Officer (MSC)
3173	Orthodontist (DC)	5525	Physical Reconditioning Officer (MSC)
3174	Periodontist (DC)	7316	Toxicologist (MSC)
3175	Prosthodontist (DC)	7960	Sanitary Engineer (MSC)
		8547	Medical Photographer (MSC)



# ADMINISTRATIVE DIVISION

The following list of publications is of particular interest to the Medical Department:

## DEPARTMENT OF THE ARMY SPECIAL REGULATIONS

SR No.	Subject	Date
40-210-10	Medical Service--International Certificate of Inoculation and Vaccination	8 Feb 50
385-10-80	Safety--Civilian Safety Training	24 Feb 50

## MILITARY DISTRICT OF WASHINGTON MEMORANDA

Memo No.	Subject	Date
5	List of Officers Under the Jurisdiction of This Headquarters with Station, Duty Assignment and Telephone Number	8 Feb 50
6	Section I - Amendment to Information List	10 Feb 50
6	Section II - Operation of Motor Vehicles	10 Feb 50
7	Establishment of Post Exchange	13 Feb 50
8	Distribution List	15 Feb 50
9	Registration of Motor Vehicles in the State of Virginia	20 Feb 50
10	Policy Governing the Assignment of Quarters to Non-commissioned Officers Within the Command	23 Feb 50

## MILITARY DISTRICT OF WASHINGTON CIRCULARS

Cir No.	Subject	Date
4	Section I - Discharge To Reenlist For Unspecified Period of Time	3 Feb 50
4	Section II - Relief from Active Duty	3 Feb 50
5	Section I - Relief from Active Duty Orders	16 Feb 50
5	Section II - Separation of Officer Personnel	16 Feb 50
5	Section III - Separation of Officer Personnel	16 Feb 50
6	Separation Orders	21 Feb 50
7	Physical Examinations for Officers Separated Under Provisions of SR 605-225-1	23 Feb 50
8	Examining and Computing Agencies	28 Feb 50

## PUBLICATIONS ORIGINATED IN OFFICE OF SURGEON, MDW

ANWMC File No.	Subject	Date
201.5	Physical Examinations	17 Feb 50
721.6	Statistical Health Report, WD AGO Form 8-122	21 Feb 50

